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SouthDakota

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MEDICAID – A STUDY FOCUSING ON COST CONTAINMENT, DEMOGRAPHICS AND COMPARISON WITH THE SYSTEMS IN OTHER STATES

Background

Medicaid is the state-federal partnership health program which serves about 50 million people in all 50 states and the U.S. territories. The program is complex in structure, and varies from state to state, but for most locales it is the single largest health program in place. Medicaid provides medical benefits to low-income people who have no medical insurance or inadequate medical insurance.

The federal role in Medicaid is limited to setting standards, issuing regulations and guidelines, and overseeing operation of the program by the states. Specific program requirements are actually established by each state. Whether a person is eligible for Medicaid and what services are available will depend on the state where he or she lives. Because Medicaid is an entitlement, once rules for eligibility and reimbursement are set, the program cannot be terminated when funds run out without legislative action.

President Truman first proposed a prepaid health insurance plan on November 19, 1945, in a special message to Congress. On July 30, 1965, President Johnson signed the Medicare and Medicaid Bill (Title XVIII and Title XIX of the Social Security Act). Since its enactment, Medicaid has evolved over time. In the proposed FY05 federal budget, 1 in every 5 federal dollars will be spent for federal health programs. In South Dakota 30.3 percent of the general fund expenditures will be for health, human services and social services categories.

Which People Does Medicaid Cover?

Federal law requires state Medicaid programs to cover certain populations and allows states the option of covering others. Medicaid is an "entitlement" program, which means that states may not exclude anyone who applies for coverage if he or she meets specified eligibility criteria. This provision makes budgeting for Medicaid somewhat difficult because enrollment may not be limited and the number of eligible people fluctuates with the economy and other variables. Although 52 million people nationally were covered by Medicaid at some point during 2003, month-by-month variations exist as people move in and out of the program.

Mandatory populations

Although state participation in Medicaid is optional, states that have Medicaid programs - and all do - must provide coverage to certain groups or "categories" of people (sometimes referred to as "categorically eligible"). Mandatory groups include the following:

- AFDC-related populations (certain parents and children). {Eligibility for children and parents in the former "Aid to Families with Dependent Children" program once automatically qualified people for Medicaid. The 1996 federal welfare reform legislation, which replaced AFDC with Temporary Assistance for Needy Families (TANF) and delinked welfare from automatic Medicaid eligibility, froze Medicaid's welfare-related eligibility levels at the former AFDC eligibility levels that were in place on July 16, 1996. The national average eligibility threshold at that time was about 40 percent of federal poverty guidelines, or $6,268 for a family of three in 2004. States may expand eligibility, but may not reduce it.}

- People who receive Supplemental Security Income (SSI), a federal cash assistance program for low-income people with disabilities who meet specified eligibility criteria.

- Pregnant women with incomes up to 133 percent of federal poverty guidelines ($12,382 for a single woman in 2004).

- Infants of women enrolled in Medicaid at the time of birth, or those in families with income up to 133 percent of poverty guidelines.

- Children under age 6 in families with income up to 133 percent of poverty guidelines.

- Children ages 6 through 18 in families with incomes at or below the poverty level.

- Children in adoption or foster care.

- Some low-income Medicare recipients (for services not covered by Medicare).

Optional populations

For many years, states had little discretion about covering additional people under Medicaid. The program was mainly designed to assist very low-income, welfare-related populations. However, the program expanded over time, most notably for children and pregnant women. The most common additional populations that states may choose to cover in their Medicaid programs include the following:

- Infants and pregnant women with family incomes up to 185 percent of federal poverty guidelines.

- Additional families, by disregarding a portion of family income, eliminating asset tests, raising income levels to adjust for inflation, or extending benefits to two-parent working families.

- Additional Medicaid recipients by increasing income eligibility levels.

- "Medically needy" people (specified low-income people who do not meet income criteria, but who have large medical expenses in proportion to their income).

- People with disabilities who would lose eligibility because of higher income, who may buy Medicaid coverage under a sliding-scale premium (the "Ticket to Work" initiative).

- Low-income uninsured women with breast or cervical cancer who have been diagnosed through the National Breast and Cervical Cancer Early Detection Program, for their cancer treatment.

- Children under the State Children's Health Insurance Program (SCHIP). Under the federal SCHIP legislation passed in 1997, states may extend Medicaid coverage to children through age 18 with family incomes of up to 200 percent of federal poverty guidelines (or they may create a non-Medicaid insurance option).

Waiver populations

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration projects which, in the judgment of the Secretary, are likely to assist in promoting the objectives of the Medicaid statute. Such waivers, usually five-year demonstration projects, must be "cost neutral" over the life of the waiver, meaning states must achieve savings in some program areas in order to cover additional people.

Although South Dakota has not sought any 1115 waivers, several states have, including the following examples:

- Minnesota covers children under age 2 in families with incomes up to 280 percent of poverty guidelines, pregnant women with incomes up to 275 percent, and other children through age 18 in families with incomes of up to 170 percent of federal poverty guidelines, and several other categories of people with incomes up to 100 percent of poverty guidelines.

- Oregon covers children and pregnant women in families with incomes of up to 185 percent of federal poverty guidelines and parents and childless adults with incomes up to poverty guidelines. Childless adults, covered by a less comprehensive benefits package, pay both monthly premiums and service copayments. In addition, Oregon subsidizes employer-sponsored insurance or individual insurance coverage for certain low-income populations through its Family Health Insurance Assistance Program. The state received a Medicaid waiver in October 2002, which allows it to receive federal Medicaid matching funds for the program.

2004 Poverty Guidelines

Size of family unit	Poverty guideline
1	$ 9,310
2	12,490
3	15,670
4	18,850
5	22,030
6	25,210
7	28,390
8	31,570
Each additional member above 8 add	3,180

For many programs, the federal government issues a poverty test criterion to determine eligibility. This table shows the current (2004) poverty guidelines.

History of South Dakota Persons Eligible for Medicaid Services

Fiscal Year Monthly Average	1998	1999	2000	2001	2002	2003
Total Eligible	61,096	65,543	70,559	77,443	85,542	91,145
Adults	26,200	25,959	26,910	27,847	29,235	30,528
Children	34,896	39,584	43,649	49,596	56,307	60,617

Appendix A gives the detail of South Dakota's Optional Coverage groups.
Appendix B is a chart comparing selected benefits of random states.

What Services Are Covered?

Similar to mandatory and optional populations for Medicaid eligibility, federal Medicaid law requires states to cover certain services and allows states to select from a menu of other optional services. Because Medicaid covers so many low income elderly people and people with serious disabilities who cannot obtain private sector coverage, its benefits package reflects these special needs. For example, Medicaid covers some services that most private insurance plans do not cover, such as nursing home and other long-term care services, and that can be especially expensive. Covered services must be available statewide, must be comparable (equal for all in a group), and must be sufficient in "amount, duration and scope" to achieve their purpose. States retain considerable flexibility in defining certain services and setting coverage guidelines.

States can, and have, set "reasonable" limits on both mandatory and optional services, such as the number of prescriptions or the number of visits to a particular type of provider. In practice, with the exception of required services for children, states have exercised wide discretion in the amount, duration, and scope of services they cover.

Influences on State Medicaid Costs

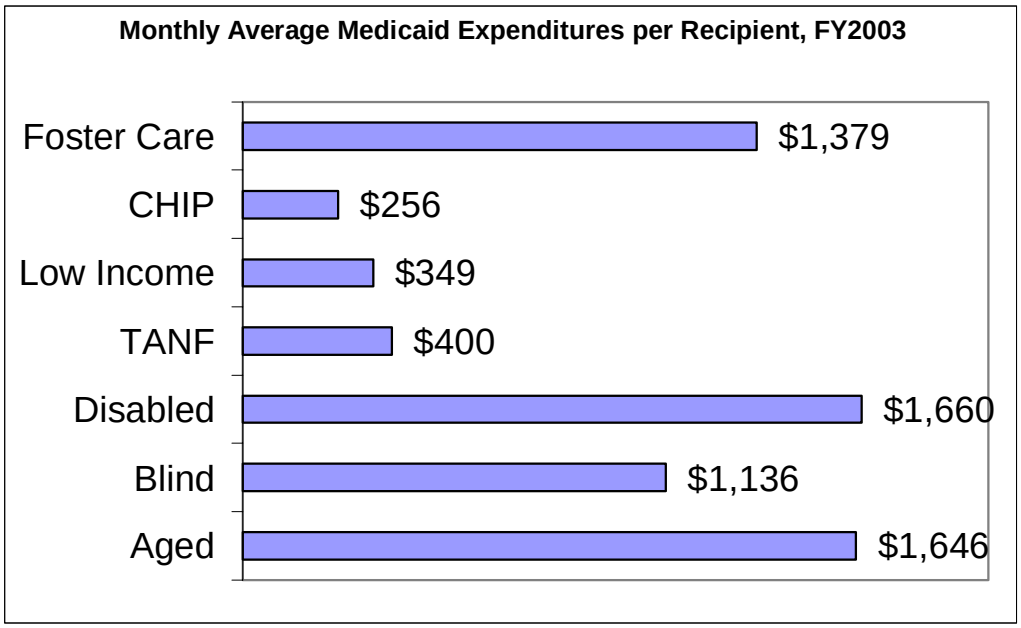
The state's Medicaid costs depend on: how many people receive care; what care they receive; who provides it; what the provider is paid; and, the basis for the payment. When unemployment rose during the recent economic downturn, more individuals qualified for Medicaid coverage as incomes declined and access to employer-sponsored insurance became more limited.

Who is covered has more of an effect on Medicaid costs than how many people are covered. On average, Medicaid spends more than nine times as much for an elderly recipient as for a child, and spending for elderly, blind and disabled people accounts for more than 70 percent of health services spending. During FY03 in South Dakota, an average 73 percent of the enrolled Medicaid population was composed of TANF and low income persons; however these two groups only used 26 percent of the actual budget. The largest two shares of the budget (68 percent) were used by the disabled and the elderly, two of the smaller groups.

Among the more expensive groups covered under Medicaid are individuals with developmental disabilities, chronic and severe mental illnesses, and the frail elderly. These groups depend on states to act as their advocates and also to fund their care. This can place state agencies in conflicting roles, with one agency having protective responsibility for the vulnerable patients while another must manage budgetary demands. Legislators face both responsibilities.

As baby boomers approach retirement age more stress will be put on Medicaid. In 1960 shortly before the Medicaid system was enacted the over 65 population in South Dakota was 71,513. The State Data Center projects that number to be 119,322 in 2005 and by 2020 it is projected to climb to 179,009. As a percentage of South Dakota's total population, that represents a 10 percent increase in the elderly population from 2000 to 2020.

Another factor on the horizon influencing health care and Medicaid is nutrition and obesity. Being overweight or obese results from daily lifestyle choices, the consequences of which gradually accumulate. In March 2004, the Centers for Disease Control announced that the second leading cause of death in 2000 was poor diet and physical inactivity. This trend is sure to have a growing role in Medicaid programs as well.



How Can States Control Medicaid Costs?

States have taken a number of longer term reforms to help control Medicaid costs, including the following examples:

FOCUS ON THE SICKEST PEOPLE. At least 21 states attempt to "manage diseases" such as asthma and diabetes in their Medicaid programs. Florida reports a $42.2 million savings over five years by providing intensive services to certain chronically ill people. CMS announced support for disease management initiatives under Medicaid in a letter to state Medicaid directors on February 25, 2004. *(Appendix C is the CMS Letter)*

REFORM LONG-TERM CARE. Long-term care services consume about 40 percent of Medicaid budgets. Maine cut the total per-person spending of Medicaid-funded long-term care by 12 percent by increasing community-based services, cutting the time that Medicaid clients stay in nursing homes, billing Medicaid for appropriate services, and tightening medical eligibility standards. Promoting private long-term care insurance also may help lessen future burdens on state budgets.

EMPHASIZE PREVENTION. Children make up about half of Medicaid enrollees. By focusing on prevention and timely acute care services for Medicaid-enrolled children, a North Carolina pilot program cut emergency room visits by 20 percent and also reduced hospital stays.

REDUCE PRESCRIPTION DRUG COSTS. States have saved millions of dollars by implementing prior authorizations, preferred drug lists and supplemental rebates, and by requiring use of generic drugs.

PROMOTE WELLNESS AND DISEASE MANAGEMENT. A statewide fitness campaign in Texas called "Texercise" educates and involves seniors and their families in physical activities and proper nutrition. This type of strategy can slow the rise of medical and social services costs, and ultimately benefit people of all ages.

USE ELECTRONIC RECORDS. Arkansas saved an estimated $30 million over 17 months by creating an integrated electronic billing, eligibility verification, payment, data collection and analysis system.

MAXIMIZE FEDERAL FUNDING. By identifying programs funded by the state that could qualify for federal matching funds under Medicaid, states could reap significant benefits. For example, certain special education, foster care, and substance abuse services may qualify for Medicaid reimbursement. In addition, states that sponsor pharmacy assistance programs for low-income residents may qualify for federal Medicaid assistance under a new Medicaid Pharmacy Plus waiver.

LEVERAGE FEDERAL FLEXIBILITY. Medicaid's 1115 waivers give states more flexibility to craft Medicaid demonstration projects. For example, Utah expanded its program to cover up to 25,000 additional low-income adults for primary and preventive services. The state projects savings in hospital and emergency room costs for previously uninsured adults. Missouri estimates savings of $11.4 million in 2002 through its premium assistance program, which subsidizes employer-sponsored insurance for eligible Medicaid workers (instead of enrolling individuals in the state's regular Medicaid plan).

EVALUATE THE PROGRAM. A number of states have achieved savings in their Medicaid programs by conducting studies or audits to identify areas where the program could be refined or improved. For example, South Carolina's Legislative Audit Council recommended a preferred drug list to save $12.8 million and an enrollment fee to save an estimated $1.4 million.

Challenges

The most obvious ways for states to trim Medicaid costs involve cutting program eligibility, services, or payments to service providers. However, each of these options has its drawbacks.

- Cutting eligibility may shift costs elsewhere, such as to other state or locally funded programs, to emergency rooms, to private insurance plans in the form of higher premiums, and to providers in the form of bad debt or charity care. These alternatives are less desirable and without the generous federal cost sharing.

- Imposing overly stringent restrictions on services such as prescription drugs may result in higher costs associated with sicker patients, including expensive hospital or nursing home care.

- Paying less can have unexpected effects on the rest of the system, as the excess costs are absorbed by other payers. Underpaid providers may shift costs to private insurance or refuse to treat Medicaid patients altogether. If providers and plans find lower payments unacceptable, paying less can reduce access as well.

Several trends can be misleading as to their impact on the entire system. Rapid growth in one category of spending is not necessarily bad because increasing the use of some services may decrease the use of more expensive services and lower costs over time.

- Outpatient and physicians' office visits increased a decade ago due to a shift from inpatient to less expensive outpatient care.

- Pharmaceutical spending has swelled alarmingly in recent years; however, it is not clear that this is undesirable. For at least some conditions, such as chronic mental illness, pharmaceuticals are an alternative to more expensive care or procedures and may slow the costly progression of disease and disability.

- Home and community-based care have been growing at double-digit rates, encouraged by the view that it often is less expensive than institutional alternatives. New community-based services create budget problems if they are not offset by decreased use of nursing facilities. More than half of Medicaid long-term care spending goes to nursing homes, although the proportion varies from state to state.

No Easy Answers

Medicaid provides literally vital-life-giving-services to the most vulnerable populations. Since its enactment, Medicaid has evolved from a program providing federal financing to states to support health coverage for their welfare population to a federal and state partnership that now provides health and long-term coverage to millions of low-income Americans. It has become the nation's largest health care program both in terms of enrollment and spending, with children and families making up the vast majority of program enrollment and the elderly and disabled accounting for the bulk of program spending.

Underlying factors point to continuing growth in Medicaid enrollment and costs adding further pressure to state budgets. Although states receive at least half their program costs from the federal government, Medicaid still accounts for a substantial portion of state budgets. Ideally, costs are saved by giving care more efficiently, eliminating unnecessary and wasteful systems, and keeping people well by preventing rather than treating illnesses. Because health care strategies tend to have complicated interaction with one another changes are not simple and do not happen overnight.

This issue memorandum was written by Sue Cichos, Senior Fiscal Analyst for the Legislative Research Council. It is designed to supply background information on the subject and is not a policy statement made by the Legislative Research Council.